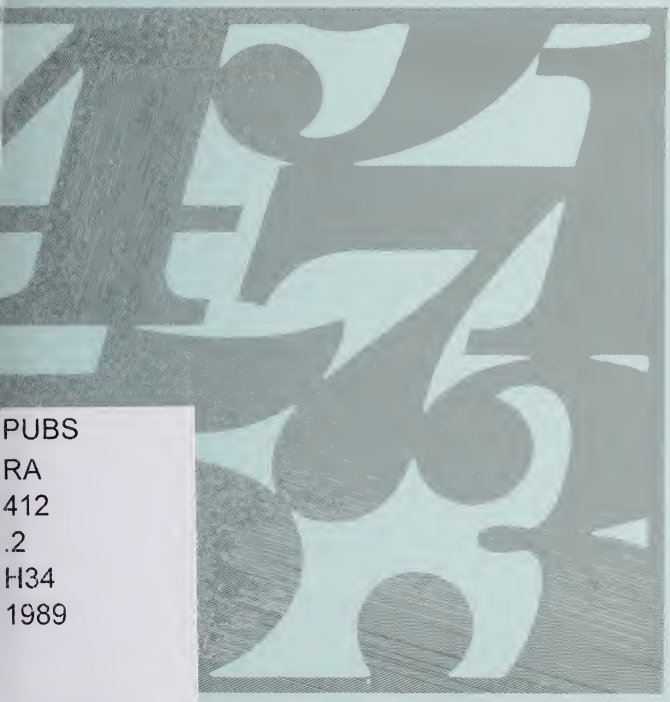
1989 HCFA Statistics



ealth Care Financing Administration
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Preface

Since the Medicare and Medicaid programs began, health care expenditures have grown faster than the rest of the economy. Medicare and Medicaid have grown even faster than health expenditures in general. This reference booklet provides significant summary information about health expenditures and Health Care Financing Administration (HCFA) programs.

The data are organized as follows:

Highlights

Growth in HCFA programs and health expenditures

Populations

- Persons enrolled for Medicare coverage increased from 19.5 million in 1967 to about 33.7 million in 1989, a 73-percent increase.

  In 1967, Medicare enrollees represented 9.7 percent of the U.S. resident population; in 1989, they represented 13.3 percent.

- Medicaid recipients (data on eligibles are not available) increased from about 10 million in calendar year 1967 to 24 million in fiscal year 1989, an increase of 140 percent.

  Data for 1989 indicate that 9 percent of the U.S. resident population received Medicaid services.

Providers/Suppliers

- During the early years of the Medicare program, the number of hospitals classified as short-stay was relatively stable, in the range of 6,100-6,200. However, during 1980, the number dropped below 6,100, and by January 1989, the number decreased to 5,758. This change is partially due to the reclassification of some short-stay hospitals to non-short-stay classification for Medicare reimbursement purposes.
- Until recently, the total number of Medicare certified beds in short-stay hospitals showed a steady increase from less than 800,000 at the beginning of the program and peaking at 1,025,000 in 1984-86. Since that time, the number has dropped to less than 1,000,000.
- The number of psychiatric hospitals grew to about 400 by 1976 where it remained until the start of the prospective payment system (PPS) in 1983. Since that time, the number has grown to 614.
- At the end of fiscal year 1988, PPS covered 5,626 or 84 percent of all hospitals.
- The number of skilled nursing facilities (SNFs) increased rapidly during the 1960s, decreased during the first half of the 1970s, and has been increasing ever since, reaching almost 7,700 by the beginning of 1989.
- After peaking in 1970, the number of home health agencies (HHAs) remained stable during most of the decade. The number of HHAs began to peak in 1978 and accelerated with the passage of the Omnibus Reconciliation Act of 1980 which permitted the certification of proprietary HHAs in States not having licensure laws. By 1986, there were almost 6,000 participating facilities. Since that time, the number has decreased to 5,673.
- Independent laboratories increased 99 percent from 2,355 in January 1968 to 4,676 in January 1989.

Expenditures

- National health expenditures were $51 billion in 1967, 6.3 percent of the gross national product (GNP). By 1990, expenditures are projected to reach $647 billion, 12 percent of GNP.
- Public expenditures on health amounted to $19 billion in 1967, 37 percent of total health expenditures. Public health expenditures are projected to reach $269 billion in 1990, 42 percent of total health expenditures.
- Federal health expenditures increased from 23 percent of all health expenditures in 1967 ($12 billion) to 30 percent in 1990 ($196 billion).
- National health expenditures per person increased from $247 in 1967 to $2,511 in 1990.
- National health expenditures are projected to reach $1,529 billion in the year 2000, representing 15 percent of the GNP.

Utilization of Medicare and Medicaid services

- About 46 million persons will receive services paid by Medicare or Medicaid in fiscal year 1989.
- One out of five, or about 10 million of these persons, will use inpatient hospital services covered by Medicare or Medicaid this year.
- Five out of six, or about 38 million of these persons, will receive reimbursable physician services under Medicare or Medicaid this year.
- About 23 million persons will receive reimbursable outpatient hospital services under Medicare or Medicaid this year.
- Over 900,000 persons will receive care in SNFs covered by Medicare or Medicaid this year.

- Over 1 million persons will receive care in intermediate care facilities covered by Medicaid this year.
- Over 2 million persons will receive reimbursable HHA visits under Medicare or Medicaid this year.
- About 16 million persons will receive prescribed drugs under Medicaid this year.

I

Populations

Information about persons covered by Medicare and Medicaid

For Medicare, statistics are based on persons enrolled for coverage. For Medicaid, recipient counts are used as a surrogate of persons eligible for coverage, as well as for persons utilizing services. Statistics are available by major program categories, by demographic and geographic variables, and as proportions of the U.S. population. Utilization data organized by persons served may be found in the Utilization section.

Medicare enrollment/trends

	Total persons	Aged persons	Disabled persons
		In millions	
July			
1966	19.1	19.1	–
1970	20.5	20.5	–
1975	25.0	22.8	2.2
1980	28.5	25.5	3.0
1985	31.1	28.2	2.9
1986	31.7	28.8	3.0
1987	32.4	29.4	3.0
1988	33.0	29.9	3.1
1989[1]	33.7	30.5	3.2
1990[1]	34.4	31.1	3.3

[1]Estimated.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System and the Office of the Actuary: Data from the Office of Medicare Cost Estimates.

Medicare enrollment/coverage

	HI and/or SMI	HI	SMI	HI and SMI	HI only	SMI only
			In millions			
All persons	33.0	32.4	31.6	31.1	1.4	0.6
Aged persons	29.9	29.3	28.8	28.2	1.1	0.6
Disabled persons	3.1	3.1	2.8	2.8	0.3	([1])

[1]Number less than 50,000.

NOTES: Data as of July 1988. HI is hospital insurance. SMI is supplementary medical insurance.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System.

Medicare enrollment/demographics

	Total	Male	Female
		In thousands	
All persons	32,980	13,929	19,051
Aged	29,879	11,967	17,912
65-74 years	17,221	7,553	9,668
75-84 years	9,556	3,553	6,003
85 years and over	3,102	861	2,241
Disabled	3,101	1,962	1,140
Under 45 years	1,044	679	365
45-54 years	670	428	242
55-64 years	1,388	855	533
White	28,483	11,996	16,487
Other races	3,502	1,533	1,970
Unknown	995	400	595

NOTE: Data as of July 1988.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System.

Medicare enrollment/end stage renal disease trends

	HI and/or SMI	HI	SMI
July			
1980	66,741	66,254	64,896
1981	72,807	72,344	70,786
1982	76,117	75,707	73,705
1983	89,427	88,847	86,868
1984	97,780	97,080	94,620
1985	103,997	103,171	100,694
1986	120,060	118,946	116,093
1987	130,939	129,657	126,003
1988	141,300	139,958	135,687

NOTES: HI is hospital insurance. SMI is supplementary medical insurance.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System.

Medicare enrollment/end stage renal disease demographics

	Number of enrollees
All persons	141,300
Age	
Under 25 years	6,772
25-44 years	36,752
45-64 years	51,727
65 years and over	46,049
Sex	
Male	76,900
Female	64,400
Race	
White	87,828
Other	48,032
Unknown	5,440

NOTE: Data as of July 1988.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System.

Medicare enrollment/HCFA region

	July 1, 1988		Enrollees as percent of population
	Resident population	Medicare enrollees	
	In thousands		
All regions	249,405	[1]32,720	13.1
Boston	12,962	1,844	14.2
New York	29,034	3,968	13.7
Philadelphia	25,791	3,567	13.8
Atlanta	43,980	6,263	14.2
Chicago	46,427	6,185	13.3
Dallas	28,393	3,231	11.4
Kansas City	12,072	1,799	14.9
Denver	7,655	849	11.1
San Francisco	34,149	3,854	11.3
Seattle	8,942	1,135	12.7

[1]Includes enrollees with unknown State of residence, but excludes those living in foreign countries.

SOURCES: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System. U.S. Bureau of the Census, State population and household estimates, with age, sex, and components of change: 1981-88. Current Population Reports. Series P-25, No. 1044. Washington. U.S. Government Printing Office, 1988.

Medicare/health maintenance organizations (HMOs)

	Pre-TEFRA HMOs[1]		Post-TEFRA HMOs[2]	
	Number of plans	Enrollees in thousands	Number of plans	Enrollees in thousands
Total prepaid	154	1,076	199	1,790
HCPPs[3]	46	612	35	549
Total HMOs	108	464	164	1,241
TEFRA risk	–	–	133	1,075
Old risk	4	37	3	17
Cost basis	65	117	24	131
Demonstrations	39	310	4	17

[1]Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982; data as of March 1985.
[2]Data as of June 1989.
[3]Health care prepayment plans.

SOURCE: Health Care Financing Administration, Office of Prepaid Health Care: Data from the Division of Contract Administration.

Aged population/projected

	1989	2000	2025	2050
	In millions			
65 years and over	31.1	35.5	59.8	70.5
75 years and over	13.0	16.9	25.1	37.8
85 years and over	3.2	4.5	6.8	15.4

SOURCE: Social Security Administration, Office of Programs: Data from the Office of the Actuary.

Life expectancy at age 65/trends

	Male	Female
	In years	
Year		
1965	12.9	16.3
1980	14.0	18.4
1985	14.4	18.6
1986	14.5	18.7
1987	14.9	18.7
1988	14.9	18.8
1989[1]	15.0	18.9

[1]Estimated.

SOURCE: Social Security Administration, Office of Programs: Data from the Office of the Actuary.

Elderly persons living below poverty level/trends

	Persons in millions	Percent
Year		
1966	5.1	28.5
1970	4.8	24.6
1980	3.9	15.7
1983	3.6	13.8
1984	3.3	12.4
1985	3.5	12.6
1986	3.5	12.4
1987	3.5	12.2

NOTE: Beginning in 1983, income estimates used for determining poverty level were based on improved measurement of interest income.

SOURCE: U.S. Bureau of the Census: Money Income and Poverty Status in the United States: 1987. Current Population Reports. Series P-60, No. 161. Washington. U.S. Government Printing Office, 1988.

Medicaid recipients/trends

	Fiscal year					
	1975	1980	1985	1988	1989[1]	1990[1]
	In millions					
Total[2]	22.0	21.6	21.8	22.9	24.0	24.8
Age 65 years and over	3.6	3.4	3.1	3.2	3.4	3.5
Blind/disabled	2.5	2.9	3.0	3.5	3.6	3.8
Dependent children under 21 years of age	9.6	9.3	9.8	10.0	10.5	10.8
Adults in families with dependent children	4.5	4.9	5.5	5.5	5.7	5.9
Other Title XIX	1.8	1.5	1.2	1.3	1.3	1.5

[1]Estimated.
[2]Eligibility categories may not add to total as some recipients are classified in more than one category during the year.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Medicaid Statistics and the Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

Medicaid recipients/State buy-ins for Medicare

	1975	1980	1985	1988
	Number in thousands			
All buy-ins[1]	2,846	2,954	2,670	2,884
Aged	2,483	2,449	2,164	2,247
Disabled	363	504	505	637
	Percent of SMI enrollees[2]			
All buy-ins	12.0	10.9	9.0	9.1
Aged	11.4	10.0	8.0	7.8
Disabled	18.7	18.9	19.2	22.5

[1]Recipients for whom the State paid Medicare supplementary medical insurance (SMI) premium for month of July.
[2]Number of SMI enrollees includes those with unknown state of residence, but excludes those living in foreign countries.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of Entitlement Requirements.

Medicaid recipients/demographics

	Fiscal year 1987 Medicaid recipients in millions	Percent distribution
Total recipients	23.1	100.0
Age	23.1	100.0
Under 6 years	5.1	22.1
6-20 years	6.6	28.6
21-64 years	7.7	33.3
65 years and over	3.7	16.0
Sex	23.1	100.0
Male	8.4	36.4
Female	14.7	63.6
Race	23.1	100.0
White	12.3	53.2
Other	9.0	39.0
Unknown	1.8	7.8

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Medicaid Statistics.

Medicaid recipients/HCFA region

	Fiscal year 1987		Recipients as percent of population
	Resident population	Medicaid recipients	
	In thousands		
All regions	[1]243,412	23,109	9.5
Boston	12,844	1,064	8.3
New York	28,895	4,551	15.8
Philadelphia	25,538	2,080	8.1
Atlanta	43,373	3,284	7.6
Chicago	46,150	4,347	9.4
Dallas	28,410	2,030	7.1
Kansas City	12,007	880	7.3
Denver	7,656	433	5.7
San Francisco	29,753	3,812	12.8
Seattle	8,785	627	7.1

[1]Excludes Arizona which operates a medical assistance program under a Section 1115 demonstration project.

SOURCES: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Medicaid Statistics. U.S. Bureau of the Census, State population and household estimates, with age, sex, and components of change: 1981-88. Current Population Reports. Series P-25, No.1044. Washington. U.S. Government Printing Office, 1988.

II

Providers /Suppliers

Information about institutions, agencies, or professionals who provide health care services and individuals or organizations who furnish health care equipment or supplies

These data are distributed by major provider/supplier categories, by geographic region, and by type of program participation. Utilization data organized by type of provider/supplier may be found in the Utilization section.

Inpatient hospitals/trends

	1975	1980	1988	1989
Total hospitals	6,707	6,780	6,715	6,658
Beds in thousands	1,132	1,152	1,125	1,116
Beds per 1,000 enrollees	51.5	46.9	39.4	38.4
Short-stay	6,084	6,111	5,856	5,758
Beds in thousands	884	988	998	988
Beds per 1,000 enrollees	40.2	40.2	34.9	34.0
Psychiatric	358	408	585	614
Beds in thousands	207	136	94	94
Beds per 1,000 enrollees	9.4	5.5	3.3	3.2
Other long-stay	265	261	274	286
Beds in thousands	42	29	33	34
Beds per 1,000 enrollees	1.9	1.2	1.1	1.2

NOTES: Facility data as of January 1. Rates based on number of aged hospital insurance enrollees. Rates for 1989 based on July 1, 1988 enrollment. Facilities certified for Medicare are deemed to meet Medicaid standards.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System.

Inpatient hospitals/HCFA region

	Short-stay hospitals	Beds per 1,000 enrollees	Long-stay facilities	Beds per 1,000 enrollees
All regions	5,758	34.0	900	4.4
Boston	246	29.3	76	8.3
New York	426	31.5	72	7.7
Philadelphia	468	30.4	109	5.5
Atlanta	1,078	35.5	164	3.4
Chicago	1,027	36.9	126	3.1
Dallas	840	39.5	146	4.4
Kansas City	514	37.2	48	3.3
Denver	324	36.8	38	5.7
San Francisco	594	30.7	97	2.7
Seattle	241	26.4	24	2.7

NOTES: Data as of January 1989. Rates based on number of aged hospital insurance enrollees as of July 1, 1988.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System.

Hospitals and units/status under the prospective payment system	
Total hospitals	6,673
Hospitals under PPS	5,626
Hospitals receiving special considerations:	597
Regional referral centers[1]	227
Sole community hospitals[1]	370
Non-PPS hospitals	1,047
Categorically exempt:	875
Psychiatric	608
Rehabilitation	100
Other long-term care	87
Children's	58
Christian Science	22
Short-stay hospitals in waiver States or demonstrations	160
Short-stay hospitals in outlying areas	4
Cancer hospitals	8
Total excluded units	1,616
Psychiatric	1,051
Rehabilitation	565

[1]Data as of March 1989.

NOTE: Data as of September 1988.

SOURCES: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System; Bureau of Policy Development: Data from the Division of Alternative Reimbursement System and Division of Hospital Payment Policy; and the Health Standards and Quality Bureau: Data from the Division of Systems Management and Data Analysis.

Long-term facilities/HCFA region

	Title XVIII and XVIII/XIX SNFs[1]	Title XIX-only SNFs	ICFs[2]	IMRs[3]
All regions	7,683	1,957	5,492	4,459
Boston	444	216	467	371
New York	761	96	53	854
Philadelphia	842	53	338	281
Atlanta	1,230	420	445	307
Chicago	1,833	443	1,306	1,471
Dallas	434	135	1,528	583
Kansas City	315	183	1,018	96
Denver	327	127	151	112
San Francisco	1,216	155	51	303
Seattle	281	129	135	81

[1]Skilled nursing facilities.
[2]Intermediate care facilities.
[3]Institutions for mentally retarded.

NOTE: Data as of January 1989.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System.

Other Medicare providers and suppliers/trends

	1975	1980	1988	1989
Home health agencies	2,254	2,858	5,769	5,673
Independent laboratories	2,994	3,448	4,487	4,676
End stage renal disease facilities	–	975	1,701	1,819
Outpatient physical therapy	115	386	1,030	1,095
Portable X-ray	131	210	395	420
Rural health clinics	–	359	459	455
Comprehensive outpatient rehabilitation facilities	–	–	141	161
Ambulatory surgical centers	–	–	852	1,016
Hospices	–	–	449	596

NOTE: Data as of January.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System.

Selected facilities/type of control

	Short-stay hospitals	Skilled nursing facilities	Home health agencies
All facilities	5,758	7,683	5,673
		Percent of total	
Nonprofit	50.0	21.7	39.8
Proprietary	20.1	71.8	34.4
Government	30.0	6.5	25.8

NOTES: Data as of January 1989. Facilities certified for Medicare are deemed to meet Medicaid standards.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System.

Periodic interim payment (PIP) facilities/trends

	1975	1980	1985	1988
Hospitals				
Number of PIP	1,524	2,276	3,290	1,411
Percent of total participating	22.5	33.8	49.0	21.3
Skilled nursing facilities				
Number of PIP	161	203	228	175
Percent of total participating	4.1	3.9	3.4	2.3
Home health agencies				
Number of PIP	86	481	952	1,120
Percent of total participating	3.8	16.0	16.0	19.8

NOTES: Data as of December 31. The Omnibus Reconciliation Act of 1986 eliminated PIP for many inpatient hospitals.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of Reports and Analysis.

Physicians/trends

	1970		1980		1987	
	Number	Percent	Number	Percent	Number	Percent
Non-Federal physicians active in patient care	255,027	100.0	361,915	100.0	461,217	100.0
Medical specialties	60,968	23.9	105,049	29.0	147,815	32.0
Surgical specialties	75,991	29.8	103,312	28.5	123,944	26.9
Other specialties	63,970	25.1	96,871	26.8	124,314	27.0
General practice	54,098	21.2	56,683	15.7	65,144	14.1

SOURCE: American Medical Association: Physician Characteristics and Distribution in the U.S. Chicago. 1988.

Physicians/HCFA region

	Non-Federal physicians active in patient care	Physicians per 100,000 population
All regions	461,217	188
Boston	31,021	242
New York	69,315	240
Philadelphia	53,841	213
Atlanta	69,473	162
Chicago	79,651	173
Dallas	42,856	152
Kansas City	18,722	157
Denver	12,357	163
San Francisco	68,982	211
Seattle	14,999	173

NOTES: Physicians as of December 1987. Civilian population as of July 1987.

SOURCE: American Medical Association: Physician Characteristics and Distribution in the U.S. Chicago. 1988.

Medicare assigned claims/HCFA region

	Net assignment rates		
	1980	1987	1988
All regions	51.5	73.1	77.3
Boston	67.4	85.5	88.5
New York	51.8	74.5	77.4
Philadelphia	61.6	84.9	88.1
Atlanta	52.3	72.1	77.3
Chicago	47.6	70.0	75.2
Dallas	50.3	69.4	73.2
Kansas City	40.4	65.2	69.4
Denver	39.5	58.0	62.7
San Francisco	53.2	74.8	79.3
Seattle	31.3	53.7	58.0

NOTE: Calendar year data.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of Reports and Analysis.

III

Expenditures

Information about spending for health care services by Medicare, Medicaid, and in the Nation as a whole

Health care spending at the aggregate levels is distributed by source of funds, types of service, geographic area, and broad beneficiary or eligibility categories. Direct out-of-pocket, other private, and non-HCFA-related expenditures are also covered in this section. Expenditures on a per-unit-of-service level are covered in the Utilization section.

HCFA and total Federal disbursements

	Fiscal year 1988 in billions
Gross national product (current dollars)	$4,779.4
Total Federal budget[1]	1,064.0
Percent of gross national product	(22.3)
Department of Health and Human Services[1]	373.6
Percent of Federal budget	(35.1)
HCFA budget	
Medicare benefit payments	85.5
Medicaid medical assistance payments	29.0
HCFA program management	1.5
State and local administration/training	1.5
Other administrative expenses	0.6
Peer review organizations	0.2
Total (unadjusted)	118.2
Offsetting and proprietary receipts	-8.8
Total net of offsetting and proprietary receipts[1]	109.4
Percent of Federal budget	(10.3)

[1]Includes off-budget entities, net of offsetting receipts.

NOTE: Numbers may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Office of Budget and Administration: Data from the Division of Budget.

Program benefit payments/trends

	Total	Medicare	Medicaid[1]
		In billions	
Calendar year			
1966	$2.5	$1.0	$1.5
1970	12.3	7.1	5.2
1980	60.9	35.7	25.2
1984	99.5	63.0	36.4
1985	109.6	69.3	40.3
1986	118.2	74.6	43.6
1987	130.6	81.2	49.4

[1]Total medical assistance payments, Federal and State expenditures combined.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Cost Estimates.

Benefit outlays by program

	Fiscal year			
	1967	1968	1988[1]	1989[1]
	In billions			
Annually				
HCFA program outlays	$5.1	$8.4	$138	$154
Federal outlays	–	6.8	115	129
Medicare	3.2	5.1	86	96
HI	2.5	3.7	52	57
SMI	0.7	1.4	34	39
Medicaid	1.9	3.3	52	58
Federal share	–	1.6	29	33
	In millions		In billions	
Monthly				
HCFA program outlays	$426	$704	$11.5	$12.9
Federal outlays	–	564	9.5	10.7
Medicare	264	427	7.1	8.0
HI	209	311	4.3	4.8
SMI	55	116	2.8	3.2
Medicaid	101	277	4.3	4.9
Federal share	–	137	2.4	2.7
	In thousands		In millions	
Hourly				
HCFA program outlays	$583	$964	$15.7	$17.6
Federal outlays	–	773	13.1	14.7
Medicare	362	585	9.8	11.0
HI	286	426	5.9	6.5
SMI	76	159	3.8	4.4
Medicaid	221	379	5.9	6.7
Federal share	–	188	3.3	3.7
	In dollars		In thousands	
Minutely				
HCFA program outlays	$9,720	$16,065	$262	$294
Federal outlays	–	12,882	218	245
Medicare	6,035	9,753	163	183
HI	4,772	7,108	99	109
SMI	1,263	2,645	64	74
Medicaid	3,685	6,313	99	111
Federal share	–	3,130	55	62

[1]Estimated.

NOTES: HI is hospital insurance. SMI is supplementary medical insurance.

SOURCE: Health Care Financing Administration, Office of Budget and Administration: Data from the Division of Budget.

Program benefit payments/HCFA region

		Medicaid	
	Medicare[1]	Computable[2]	Net adjusted[3]
		In millions	
All regions	[4]$85,501	$51,830	$29,046
Boston	5,066	3,859	2,023
New York	9,493	11,688	5,781
Philadelphia	10,337	5,046	2,808
Atlanta	14,928	6,773	4,532
Chicago	16,894	9,751	5,544
Dallas	8,175	4,207	2,656
Kansas City	4,417	1,761	1,051
Denver	2,025	1,143	706
San Francisco	11,874	6,083	3,079
Seattle	2,292	1,518	864

[1]Distribution by region is estimated.
[2]Total medical assistance payments computable for Federal funding.
[3]Net adjusted Federal share.
[4]Excludes residence unknown and residents of foreign countries.

NOTE: Data as of fiscal year 1988.

SOURCES: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System; Office of the Actuary: Data from the Office of Medicare Cost Estimates; and the Bureau of Quality Control: Data from the Division of Financial Management.

Medicare/trust fund projections

	Fiscal year		
	1988	1989	1990
	In billions		
HI benefit payments[1]	$51.9	$57.1	$63.1
Aged	46.2	50.8	55.9
Disabled	5.7	6.3	7.2
SMI benefit payments	33.7	38.7	46.1
Aged	30.0	34.6	41.3
Disabled	3.7	4.2	4.8

[1]Excludes peer review organization expenditures.

SOURCE: Health Care Financing Administration, Office of Budget and Administration: Data from the Division of Budget.

Medicare/type of benefit

	Fiscal year 1988 benefit payments in millions	Percent distribution
Total HI	$51,858	100.0
Inpatient hospital	48,857	94.2
Skilled nursing facility	649	1.3
Home health agency	2,262	4.4
Hospice	90	0.2
Total SMI	33,682	100.0
Physician/other suppliers	24,243	72.0
Outpatient hospital	6,460	19.2
Home health agency	51	0.2
Group practice prepayment	1,952	5.8
Independent laboratory	976	2.9

NOTES: HI is hospital insurance. SMI is supplementary medical insurance. Numbers may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicare Cost Estimates.

Medicaid/basis of eligibility

	Fiscal year 1987 vendor payments in millions	Percent distribution
Total	$45,050	100.0
Age 65 years and over	16,037	35.6
Blind/disabled	16,817	37.3
Dependent children under 21 years of age	5,508	12.2
Adults in families with dependent children	5,592	12.4
Other Title XIX	1,078	2.4

NOTE: Numbers may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Medicaid Statistics.

Medicaid/type of service

	Fiscal year	
	1986	1987
	In billions	
Total vendor payments	$41.0	$45.0
	Percent of total	
Inpatient services	28.0	28.2
General hospitals	25.3	25.1
Mental hospitals	2.7	3.1
Skilled nursing facility services	13.8	13.2
Intermediate care facility services	28.9	28.6
Mentally retarded	12.4	12.4
All other	16.5	16.2
Physician services	6.2	6.2
Dental services	1.3	1.2
Other practitioner services	0.6	0.6
Outpatient hospital services	4.8	4.9
Clinic services	2.0	2.1
Laboratory and radiological services	1.0	1.1
Home health services	3.3	3.8
Prescribed drugs	6.6	6.6
Family planning services	0.6	0.5
Early and periodic screening	0.2	0.3
Rural health clinic services	([1])	([1])
Other care	2.7	2.7

[1]Less than 0.05 percent.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Medicaid Statistics.

National health care/trends

	Calendar year			
	1965	1980	1985	1987
National total in billions	$41.9	$248.1	$419.0	$500.3
Percent of GNP	5.9	9.1	10.4	11.1
Per capita amount	$206	$1,055	$1,696	$1,987
Source of funds		Percent of total		
Private	73.8	57.6	58.2	58.6
Public	26.2	42.4	41.8	41.4
Federal	13.2	28.6	29.4	28.9
State/local	13.0	13.8	12.4	12.5

NOTE: GNP is gross national product.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Cost Estimates.

National health care/projections

	Calendar year		
	1990	1995	2000
National total in billions	$647.3	$999.1	$1,529.3
Percent of GNP	12.0	13.4	15.0
Per capita amount	$2,511	$3,739	$5,551
Source of funds		Percent of total	
Private	58.4	57.6	57.5
Public	41.6	42.4	42.5
Federal	30.2	31.8	32.6
State/local	11.4	10.6	9.9

NOTE: GNP is gross national product.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Cost Estimates.

National health care/type of expenditure

	National total in billions	Per capita amount	Percent paid		
			Total	Medicare	Medicaid
Total	$500.3	$1,987	27.0	16.6	10.4
Health services and supplies	483.2	1,919	27.9	17.2	10.7
Personal health care	442.6	1,758	29.5	18.4	11.2
Hospital care	194.7	773	36.5	27.4	9.1
Physicians' services	102.7	408	26.0	21.7	4.3
Nursing home care	40.6	161	45.3	1.4	43.9
Other personal care	104.6	415	13.8	4.9	9.0
Other services and supplies	40.7	161	10.6	4.4	6.2
Research and construction	17.1	68	–	–	–

NOTE: Data as of calendar year 1987.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Cost Estimates.

Personal health care/payment source

	Calendar year			
	1970	1980	1985	1987
	In billions			
Total	$65.4	$219.7	$368.3	$442.6
	Percent			
Total	100.0	100.0	100.0	100.0
Private	65.7	60.6	59.8	60.4
Out-of-pocket	40.5	28.7	28.2	27.8
Other private	25.1	32.0	31.7	32.6
Public	34.3	39.4	40.2	39.6
Medicare	10.9	16.2	18.8	18.4
Medicaid	8.0	11.5	10.9	11.2
Other public	15.5	11.6	10.4	10.1

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Cost Estimates.

Per capita spending and sources of funds for personal health care expenditures for persons 65 years of age or over, 1977 and 1984

	Total	Hospital care	Physicians' services	Nursing home care	Other care
Calendar year 1977					
Total per capita	$1,785	$777	$320	$440	$248
			Percent of total		
Private	36.1	12.3	42.7	50.7	76.2
Consumer	35.7	12.0	42.7	50.0	75.5
Out-of-pocket	29.3	4.9	27.6	49.2	72.3
Insurance	6.4	7.1	15.1	0.8	3.2
Other	0.4	0.3	0.0	0.7	0.6
Government	63.9	87.7	57.3	49.3	23.8
Medicare	44.1	74.5	53.4	3.3	9.6
Medicaid	13.9	3.9	3.0	41.6	10.4
Other	5.9	9.3	0.9	4.4	3.8
Calendar year 1984					
Total per capita	$4,202	$1,900	$868	$880	$554
			Percent of total		
Private	32.8	11.4	39.7	51.9	65.3
Consumer	32.4	11.0	39.6	51.2	64.8
Out-of-pocket	25.2	3.1	26.1	50.1	59.9
Insurance	7.2	7.9	13.5	1.1	4.9
Other	0.4	0.4	0.0	0.7	0.5
Government	67.2	88.6	60.3	48.1	34.7
Medicare	48.8	74.8	57.8	2.1	19.9
Medicaid	12.8	4.8	1.9	41.5	11.4
Other	5.6	9.1	0.7	4.4	3.4

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Cost Estimates.

IV

Utilization

Information about the use of health care services

Utilization information is organized by persons receiving services and alternately by services rendered. Measures of health care usage include: persons served, units of service (e.g., discharges, days of care, etc.), and dimensions of the services rendered (e.g., average length of stay, charge per person or per unit of service). These utilization measures are aggregated by program coverage categories, provider characteristics, type of service, and demographic and geographic variables.

Medicare/short-stay hospital utilization

	Fiscal year				
	1983	1984	1985	1987[1]	1988[1]
Discharges					
Total in millions	11.7	11.5	10.9	10.6	10.8
Rate per 1,000 enrollees	397	386	359	335	336
Days of care					
Total in millions	117	105	95	94	96
Rate per 1,000 enrollees	3,978	3,544	3,125	2,986	3,000
Average length of stay per discharge	10.0	9.2	8.7	8.9	8.9
Total charges					
Amount in billions	$55	$56	$55	$70	$80
Per day	$470	$535	$605	$740	$830

[1]Estimated from American Hospital Association data to account for incomplete Medicare data.

NOTE: Includes admissions and transfers to excluded units of hospitals under prospective payment system.

SOURCES: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System. American Hospital Association: Data from the Community Hospital Panel Survey.

Medicare average length of stay/trends

	Fiscal year					
	1983	1984	1985	1986	1987	1988
Total short-stay hospitals	10.0	9.1	8.7	8.7	8.9	8.9
PPS only	–	8.0	7.9	[2]8.2	[3]8.5	8.5
Non-PPS[1]	10.0	10.1	12.5	13.4	13.3	13.0
Excluded units	–	18.0	18.8	19.2	19.7	19.5

[1]Includes pre-PPS experience, hospitals in waiver States, cancer hospitals, PPS excluded units, demonstration hospitals, and hospitals in outlying areas.

[2]Short-stay hospitals in Massachusetts transitioned into PPS beginning September 1985.

[3]Short-stay hospitals in Puerto Rico transitioned into PPS beginning October 1, 1987.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System.

Medicare long-term care/trends

	Skilled nursing facilities		Home health agencies	
	Persons served in thousands	Served per 1,000 enrollees	Persons served in thousands	Served per 1,000 enrollees
Calendar year				
1981	251	9	1,005	35
1982	252	9	1,172	40
1983	264	9	1,338	45
1984	299	10	1,522	50
1985	315	10	1,576	51
1986	304	10	1,601	50
1987	293	9	1,575	49

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System.

Medicare persons served/trends

	Calendar year				
	1967	1975	1980	1985	1987
Aged persons served per 1,000 enrollees					
HI and/or SMI	367	528	638	722	754
HI	203	221	240	218	210
SMI	365	536	652	739	776
Disabled persons served per 1,000 enrollees					
HI and/or SMI	–	450	594	668	696
HI	–	219	246	226	219
SMI	–	471	634	715	748

NOTES: HI is hospital insurance. SMI is supplementary medical insurance. Persons are those for whom Medicare Trust Fund payments were made.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System.

Medicare persons served/projections

	Fiscal year				
	1988	1989	1990	1991	1992
	In millions				
HI					
Aged					
Enrollees	28.8	29.4	30.0	30.5	31.0
Persons served	5.8	6.0	6.2	6.5	6.7
Disabled					
Enrollees	3.1	3.2	3.2	3.3	3.4
Persons served	0.7	0.7	0.7	0.7	0.8
SMI					
Aged					
Enrollees	28.6	29.3	29.9	30.4	30.9
Persons served	22.5	23.2	23.9	24.4	25.0
Disabled					
Enrollees	2.8	2.9	3.0	3.0	3.1
Persons served	2.1	2.2	2.2	2.3	2.4

NOTES: HI is hospital insurance. SMI is supplementary medical insurance. Enrollment represents actuarial estimates of average monthly enrollment during the fiscal year for residents of Social Security areas.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicare Cost Estimates.

Medicare persons served/HCFA region

	Aged persons served in thousands	Served per 1,000 enrollees	Disabled persons served in thousands	Served per 1,000 enrollees
All regions[1]	22,148	760	2,102	699
Boston	1,308	780	106	717
New York	2,717	768	262	655
Philadelphia	2,525	793	239	727
Atlanta	4,206	769	460	706
Chicago	4,153	751	398	706
Dallas	2,160	754	198	662
Kansas City	1,269	772	99	705
Denver	564	738	43	665
San Francisco	2,487	725	241	733
Seattle	751	739	62	687

[1]Excludes residents of foreign countries.

NOTES: Data as of calendar year 1987 for persons served under hospital insurance and/or supplementary medical insurance. Based on utilization for fee-for-service and excludes utilization under alternative payment systems such as health maintenance organizations.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System.

Medicare/end stage renal disease (ESRD)

	Calendar year	
	1986	1987
Total enrollees[1]	120,060	130,939
Dialysis patients[2]	90,886	98,432
In-center	73,800	80,149
Home	17,086	18,283
Transplants performed[3]	8,976	8,967
Living donor	1,887	1,907
Cadaveric donor	7,089	7,060
Average dialysis payment rate		
Hospital-based facilities	$129	$129
Freestanding facilities	$125	$125

[1]Medicare ESRD enrollees as of July 1.
[2]Includes Medicare and non-Medicare patients receiving dialysis as of December 31.
[3]Includes kidney transplants for Medicare and non-Medicare patients.

SOURCES: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System and the Bureau of Policy Development: Data from the Division of Dialysis and Transplant Payment Policy.

Medicaid/type of service

	Fiscal year 1987 Medicaid recipients in thousands
Total	23,109
Inpatient services	
General hospitals	3,767
Mental hospitals	57
Skilled nursing facility services	572
Intermediate care facility services	
Mentally retarded	149
All other	849
Physician services	15,373
Dental services	5,131
Other practitioner services	3,542
Outpatient hospital services	10,979
Clinic services	2,183
Laboratory and radiological services	7,596
Home health services	609
Prescribed drugs	15,083
Family planning services	1,652
Early and periodic screening	2,234
Rural health clinic services	129
Other care	3,594

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Medicaid Statistics.

Medicaid/units of service

	Fiscal year 1987 units in thousands
General hospital	
Total discharges	3,558
Recipients discharged	2,525
Total days of care	23,124
Skilled nursing facility	
Total recipients	537
Total days of care	112,466
Intermediate care facility mentally retarded	
Total recipients	140
Total days of care	45,611
Intermediate care facility all other	
Total recipients	834
Total days of care	216,292
Physician visits	86,743
Rural health clinic visits	339
Home health service visits	31,912
Drug prescriptions	202,373

NOTE: Based on reporting States.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Medicaid Statistics.

V

Administrative /Operating

Information on activities and services related to oversight of the day-to-day operations of HCFA programs

Included are data on Medicare contractors, contractor activities and performance, HCFA and State agency administrative costs, quality control, and summaries of the operation of the Medicare trust funds.

Medicare administrative expenses/trends

	Administrative expenses	
	Amount in millions	As a percent of benefit payments
HI Trust Fund		
1970	$157	3.1
1975	266	2.4
1980	512	2.0
1985	834	1.8
1986	664	1.3
1987	793	1.6
1988	815	1.6
SMI Trust Fund		
1970	237	12.0
1975	462	10.8
1980	610	5.7
1985	933	4.1
1986	1,060	4.0
1987	921	3.0
1988	1,260	3.7

NOTES: Calendar year data. HI is hospital insurance. SMI is supplementary medical insurance.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicare Cost Estimates.

Medicare/contractors

	Intermediaries	Carriers
Blue Cross/Blue Shield	45	26
Other	6	8

NOTES: Data as of January 1989. Reference to intermediaries as Part A has been dropped in recognition of the fact that intermediaries also service Part B institutional bills.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of Contracts.

Medicare/appeals

	Intermediary reconsiderations	Carrier reviews
Number received	80,589	5,705,831
Percent reversal rate[1]	37.5	56.9

[1]Excludes withdrawals and dismissals.

NOTE: Data as of fiscal year 1988.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of Reports and Analysis.

Medicare/claims processing costs

	Net unit cost per claim			
	1975	1980	1985	1988
Intermediaries	$3.84	$2.96	$2.33	$1.82
Carriers	2.90	2.33	1.88	1.57

NOTE: Fiscal year data.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of Contractor Financial Management.

Medicare/claims processing

	Intermediaries	Carriers
Claims processed in millions	71.8	373.3
Total costs in millions	$398.7	$761.9
Claims processing costs in millions	$128.2	$555.6
Claims processing unit costs	$1.66	$1.20
Range		
High	$2.18	$2.04
Low	$1.24	$0.99

NOTE: Data as of fiscal year 1988.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of Contractor Financial Management.

Medicare/claims received

	Claims received
Intermediary claims	
received in thousands	72,625
	Percent of total
Inpatient hospital	15.8
Outpatient hospital	66.1
Home health agency	7.0
Skilled nursing facility	1.2
Other	9.9
Carrier claims	
received in thousands	386,763
	Percent of total
Assigned	77.3
Unassigned	22.7

NOTE: Data as of calendar year 1988.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of Reports and Analysis.

Medicare/reasonable charge reductions

	Assigned	Unassigned
Claims approved		
Number in thousands	271,225	76,503
Percent reduced	85.6	86.4
Total covered charges		
Amount in millions	$37,275	$9,005
Percent reduced	29.8	25.0
Amount reduced per claim	$40.91	$29.42

NOTE: Data as of calendar year 1988.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of Reports and Analysis.

Medicaid/administration[1]

	Fiscal year	
	1987	1988[2]
	In thousands	
Total payments computable for Federal funding	$2,373,283	$2,677,359
Federal share of current expenditures:		
Family planning	7,208	11,465
Design, development or installation of MMIS[3]	23,825	32,485
Skilled professional medical personnel	117,928	105,761
Operation of an approved MMIS[3]	346,300	384,848
Other financial participation	745,461	898,638
Mechanized systems not approved under MMIS[3]	16,874	27,565
Total administration	1,257,596	1,482,950
Net adjusted Federal share	[4]1,372,973	1,538,812

[1]The effect of section 2161 of the Omnibus Budget Reconciliation Act of 1981 is not included in this schedule.
[2]State estimates as submitted November 1988. Net adjusted Federal share includes cash-flow adjustments.
[3]Medicaid Management Information System.
[4]Includes Federal share of current expenditures plus State reported and Health Care Financing Administration adjustments.

SOURCE: Health Care Financing Administration, Bureau of Quality Control: Data from the Division of Financial Management.

Quality control/Medicare Part B carriers

	Average carrier error rate			
	1977	1985	1987	1988
Occurrence (Claims processing errors per 100 line items)	8.7	6.4	5.2	5.0
Assigned	8.3	5.7	4.9	4.8
Unassigned	9.2	7.7	5.9	5.7
Payment/deductible (Dollar error per $100 of submitted charges) without nonreview penalty	1.9	1.8	1.2	1.0
Assigned	1.8	1.7	1.2	1.0
Unassigned	2.0	1.8	1.4	1.2

NOTE: Calendar year data.

SOURCE: Health Care Financing Administration, Bureau of Quality Control: Data from the Division of Performance Evaluation.

Quality control/Medicaid

	Eligibility national average error rate[1] in percent of dollars
Fiscal year	
1980	5.1
1982	3.8
1983	2.8
1984	2.7
1985	2.7
1986	2.5
1987[2]	2.3

[1]Excludes Supplemental Security Income determinations.
[2]Estimated.

NOTE: Beginning in 1982 the Tax Equity and Fiscal Responsibility Act of 1982 mandated the exclusion of certain errors from the Medicaid Quality Control System, thereby lowering error rates.

SOURCE: Health Care Financing Administration, Bureau of Quality Control: Data from the Division of Program Performance.

Reference

Selected reference material including cost-sharing features of the Medicare program, program financing, and Medicaid Federal medical assistance percentages

Program financing

Medicare/source of income

Hospital insurance trust fund:
1. Payroll taxes*
2. Transfers from railroad retirement account
3. General revenue for
   a. Uninsured persons
   b. Military wage credits
4. Premiums from voluntary enrollees
5. Interest on investments

*Contribution rate	1988	1989	1990
		Percent	
Employees and employers, each	1.45	1.45	1.45
Self-employed	2.90	2.90	2.90

Calendar year 1989 maximum taxable base: $48,000
Calendar year 1990 maximum taxable base: $50,400 (projected)

Hospital insurance catastrophic coverage reserve trust fund:
1. Supplemental Medicare premium**
2. Interest on investments

Contribution rate:
$22.50 per $150 of Federal income tax liability up to a maximum of $800 per enrollee

Supplementary medical insurance trust fund:
1. Premiums paid by or on behalf of enrollees
2. General revenue
3. Interest on investments
4. Catastrophic coverage monthly premium
5. Supplemental Medicare premium**

**Divided between HI and SMI catastrophic coverage

Medicaid/financing
1. Federal contributions (ranging from 50 to 80 percent for fiscal year 1990)
2. State contributions (ranging from 20 to 50 percent for fiscal year 1990)

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicare Cost Estimates.

Selected Medicare provisions of the Medicare Catastrophic Coverage Act of 1988

Benefits (effective date)	Provisions
Hospital insurance (1/1/89)	
Inpatient hospital	One deductible of $560 for each calendar year. No day limitations on general hospital care. Special hold harmless provisions for spells of illness in effect at the end of 1988. Special carryover provisions for deductibles incurred in December of 1989 and following years.
Skilled nursing facility (SNF)	Coinsurance amount equal to 20 percent of the national average per diem Medicare reasonable cost. This applies to first 8 days in a calendar year ($25.50 in 1989). Limit of 150 SNF days per calendar year. Three-day prior hospitalization requirement eliminated.
Hospice	Addition of an extension period of indefinite length beyond two 90-day and subsequent 30-day periods.
Home health agency	(See Supplementary medical insurance)
Blood	One deductible equal to first 3 pints/calendar year (reduced to the extent that a blood deductible has been paid under Part B).
Limitations	
Inpatient psychiatric hospital days	190 nonrenewable days.

Benefits (effective date)	Provisions - continued
Supplementary medical insurance (1/1/90)	
Physician and other professional services and suppliers	Beneficiary liability for approved charges for services and supplies covered by supplementary medical insurance (SMI) limited to $1,370 annually (this limit will increase each year). Once the $1,370 (or applicable annual limit) beneficiary liability is reached, Medicare will pay 100 percent of all remaining approved charges for most services under SMI for the remainder of the calendar year. In future years, the catastrophic limit will be set at a level to ensure that 7 percent of fee-for-service Part B enrollees reach the limit.
Blood	Once the catastrophic limit is met, any unmet blood deductible will not be required.
Screening mammography	Payments may be made for screening mammographies consistent with frequency limitations, based on age and risk, and subject to payment limits.
Home respite care	Provides temporary services in the home as relief to an individual who lives with and normally helps a Medicare beneficiary. The beneficiary requires assistance with daily activities and who has met either the supplementary medical insurance limit or the annual deductible for outpatient prescription drugs. Care includes a total of up to 80 hours in a 12 month period, but not to exceed 80 hours in any calendar year.

Benefits (effective date)	Provisions - continued
Home health care	Intermittent is legislatively redefined as less than 7 days a week, with daily care provided for up to 38 consecutive days.
Limitations	
Physician outpatient mental health services	Annual limitation on program payments of $1,100.
Independent outpatient physical therapy	Annual limitation on program payments of $400.
Independent outpatient occupational therapy	Annual limitation on program payments of $400.
Home health care	Unlimited visits subject to definition of intermittent care and limitations on consecutive days.
Catastrophic drug insurance	
First year immunosuppressive drugs after covered transplant (1/1/90)	No regular SMI or drug deductible applicable. 20 percent beneficiary liability.
Home intravenous (IV) drugs (1/1/90)	Coverage for certain IV drugs in a home setting. If IV is initiated in the hospital, the drug deductible ($550 in 1990) is not applicable. 20 percent beneficiary liability.
Extended immunosuppressive drug therapy as a drug treatment after noncovered transplants (1/1/90)	Coverage provided subject to $550 drug deductible in 1990 and 50 percent beneficiary liability. In years following 1990, the drug deductible and coinsurance percentage will be the same applying to all other prescription drugs.

Benefits (effective date)	Provisions - continued
Other prescription drugs and insulin (1/1/91)	In 1991, the deductible will be $600 and the coinsurance 50 percent. In 1992, the deductible will be $652 and the coinsurance 40 percent. In subsequent years, the drug deductible will be adjusted to keep the proportion of enrollees receiving benefits at 16.8 percent.

SOURCE: Health Care Financing Administration, Office of Legislation and Policy: Data from the Division of Legislation.

Geographical jurisdictions of HCFA regional offices and Federal medical assistance percentages (FMAP) fiscal year 1990

I. Boston	FMAP
Connecticut	50
Maine	65
Massachusetts	50
New Hampshire	50
Rhode Island	55
Vermont	63
II. New York	
New Jersey	50
New York	50
Puerto Rico	50
Virgin Islands	50
Canada	–
III. Philadelphia	
Delaware	50
District of Columbia	50
Maryland	50
Pennsylvania	57
Virginia	50
West Virginia	77
IV. Atlanta	
Alabama	73
Florida	55
Georgia	62
Kentucky	73
Mississippi	80
North Carolina	67
South Carolina	73
Tennessee	70
V. Chicago	
Illinois	50
Indiana	64
Michigan	55
Minnesota	53
Ohio	60
Wisconsin	59
VI. Dallas	FMAP
Arkansas	75
Louisiana	73
New Mexico	72
Oklahoma	68
Texas	61
VII. Kansas City	
Iowa	63
Kansas	56
Missouri	59
Nebraska	61
VIII. Denver	
Colorado	52
Montana	71
North Dakota	68
South Dakota	71
Utah	75
Wyoming	66
IX. San Francisco	
Arizona	61
California	50
Hawaii	54
Nevada	50
American Samoa	50
Guam	50
N. Mariana Islands	50
Mexico	–
X. Seattle	
Alaska	50
Idaho	73
Oregon	63
Washington	54

SOURCE: Health Care Financing Administration, Bureau of Quality Control: Data from the Division of Financial Management.

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